FY 22
Retiree Benefit Guide

INTRODUCTION

You're a valued retiree of Travis County, and your health and wellbeing are important to us. We are proud to provide you and your dependents with valuable and significant benefits. In this resource guide you will find benefit summaries, eligibility requirements, costs, contact numbers and addresses as well as other general information. Travis County is committed to maintaining a comprehensive and competitive benefits program and in return, we encourage you to read this Guide to gain an understanding of what your benefits have to offer and how to use them.

Every effort has been made to ensure that this information is accurate. It is not intended to replace any legal plan documents or contracts which contain the complete provisions of any benefit. In case of any discrepancy between this guide and the legal plan document or contract, the legal plan document or contract will govern in all cases.

RETIREE RESPONSIBILITIES

It is very important for retirees to:

- Keep contact information updated, this includes your address, phone number and email address.
- Keep beneficiary designation updated. To ensure that life insurance is paid to the correct person, it is very important to keep your beneficiary updated.
- Retirees and their dependents are required to enroll in Medicare Parts A & B at age 65. Contact the Social Security Administration 3 months prior to turning age 65 to enroll. Travis County offers a custom Medicare Advantage Plan for retirees and dependents over the age of 65.

To make changes, contact the Benefits Office at 512-854-0404 or by email at BenefitsTeam@traviscountytx.gov.

KEY PLAN CHANGES AND ENHANCEMENTS FOR FY22

Travis County Health Plans Changes:

- *Increase in medical plan premiums (UHC Plans) and Humana Advantage Plan premiums*

Travis County Dental, Vision, and Life Plans Changes:

- *New Dental vendor*
- *Decrease in dental plan premiums*

WHAT'S INSIDE?

Benefit Contact Information

Travis County Human Resources Management Department
700 Lavaca Street, Suite 420
Austin, TX 78701
Benefit Line- 512.854.0404
Email- BenefitsTeam@traviscountytx.gov
Online- http://traviscentral
Contact the vendors directly for:
ID cards, claims, benefits, or coverage information

Travis County Health Insurance Plans
United Healthcare (UHC)
Group #: 701254
P.O. Box 30555
Salt Lake City, UT 84130-0555
866.649.4873 (Members)
877.237.8576 (Retiree Billing Questions)
http://www.myuhc.com
App: Health4Me

Medicare Advantage Plan
Humana
Plan Option: 079/402
866.396.8810
www.humana.com
App: MyHumana

Travis County Employee Health Clinic
Downtown Clinic – 512.854.5509
Airport Blvd Clinic – 512.854.7998
Del Valle Clinic – 512.854.1282

Pharmacy Benefit Manager
OptumRx
844.265.1719
844.368.8732 (Rx services)
855.427.4682 (specialty)
https://www.optumrx.com
App: OptumRx

Vision Insurance
Davis Vision
877.923.2847
Client Code 3632
http://www.davisvision.com
App: DavisVision

Dental Insurance Plans
UnitedHealthcare
Policy #: 1530869
P.O. Box 30567
Salt Lake City, UT 84130
877.816.3596
http://www.myuhc.com
App: Health4Me

Life Insurance
Cigna
1601 Chestnut Street
Philadelphia, PA 19192
800.36.Cigna (800.362.4462)
www.Cigna.com
App: myCigna

Texas County & District Retirement System (TCDRS)
P.O. Box 2034
Austin, TX 78768-2034
800.823.7782 or 512.328.8889
http://www.tcdrs.org

RETIREE ELIGIBILITY

As a Travis County retiree, benefits are available to you after you are vested. You are vested with TCDRS when you meet one of the following requirements:

- Age 60 with 8 years of service; or
- Any age with 30 years of service; or
- Your age plus years of service equals 75 (also called the rule of 75)

Please note, you may use time from specified other Texas governmental entities to help meet your TCDRS vesting requirement.

The following benefits are available to County retirees:

- Travis County Health Insurance (Includes Travis County Health Clinic)
- Dental Insurance
- Vision Insurance
- Life Insurance

ENROLLMENT

The Travis County Benefit Plan Year begins on October 1st of each year and continues through September 30th of the following calendar year. As a retiree you are allowed to make elections and/or changes only during certain enrollment periods. You can enroll in benefits during your New Retiree Enrollment period, if you have an approved Qualified Life Event (QLE) or during Open Enrollment. Please review the additional information in the following sections regarding enrollment periods.

New Retiree Enrollment

As a new retiree of Travis County, you are eligible for benefits the first of the month following your retirement date. New retirees will be given an initial enrollment period of 30 days after their retirement date to make benefit elections for the rest of the benefit plan year. During this time, retirees are allowed to add, delete or change benefit elections. However, retirees cannot add new dependents to their coverage upon retirement. Only dependents who were covered under the active employee benefits are eligible for benefits under the retiree plan. If you decline coverage as a new retiree, you are ineligible to participate in benefits in the future.

Open Enrollment

Each year we offer an opportunity to review your current benefits and make changes. During Open Enrollment you are allowed to add, remove or change your benefits without a qualifying life event. Changes made during Open Enrollment are effective October 1st or Jan 1st (for Humana). If a dependent is dropped by the retiree, the dependent loses eligibility on the retiree plan, which means the retiree can never add the dependent back on to the benefits. New dependents cannot be added to retiree benefits during open enrollment.

An enrollment form will be mailed to your home address. If you need to make changes, indicate the changes on the enrollment form and mail it back. If you are not making any changes, do not return the enrollment form. If you do not make any changes, your benefits will remain in effect for the next plan year.

Benefit Changes during the Plan Year

You cannot change your election unless you have a Qualifying Life Event. A complete list of what the IRS considers a qualifying event is listed in your SPD, but in general, they include:

- Changes in your marital status: divorce, annulment, or death of spouse
- Changes in your dependent's status: death or the dependent loses eligibility due to age
- Changes in your employment status
- Changes in a permanent residence that result in different available plan options

Note that any change in coverage must be consistent with the life status change. You have 30 days from the qualifying event to change your coverage election. Contact the Benefits office to determine if your life event qualifies for the change and to determine the proper documentation required to make the change.

Remember you may not add any new dependents to your retiree coverages.

If the covered retiree passes away, the covered retiree surviving spouse (and dependents) may continue coverage for life as long as premiums are paid.

If you terminate retiree benefits, you are ineligible to participate in Travis County benefits in the future.

MEDICARE ENROLLMENT

If you or your dependent are approaching age 65 and enrolled in the Travis County health plan, you're required to enroll in Medicare Part A and B. In most cases if you're drawing SSA benefits, you'll be automatically enrolled in Medicare Part A and B. If you're retired but not receiving SSA benefits, you will not be automatically enrolled. The coverage is effective the first day of the month you turn 65. Contact the Social Security Office three months prior to your 65th birthday to enroll.

How do I enroll in Medicare Part A and B?

- Apply online at www.ssa.gov/benefits/medicare
- Visit your local Social Security Office
- Call Social Security at 800-772-1213

How much does Medicare cover?

Traditional Medicare covers 80% of covered services after you meet the $185 deductible. At age 65, your County insurance will no longer cover primary on your medical services, even if you are not enrolled in Medicare. It is very important to enroll in Medicare Part A and B in order to have complete coverage. If you are not enrolled in Medicare Part A and B at age 65, the County insurance will only pay up to 20% of your medical services, you'll be responsible for paying the 80% Medicare would have paid.

Enrollment Options

Travis County offers two Medicare eligible plans for retiree and dependents at age 65.

1. Humana Medicare Advantage Plan
    - A PPO plan that replaces traditional Medicare
    - Not required to meet the $185 Medicare deductible
    - Works with your Medicare Part A and B to cover 100% of your medical services with no deductibles
    - Will only need one medical ID card to present to doctors and the pharmacy
    - Includes extra discounts, services and wellness programs

2. United HealthCare
    - Is secondary to Medicare Part A and B and pays up to 20% of covered medical services depending on which plan you are enrolled in.
    - Will have to meet the Medicare deductible and also any applicable deductibles and copays on the UHC plan
    - Will need to present Medicare card and UHC ID card to doctors
    - Providers must bill Medicare first or UHC will deny claims

For more details, view page 4-11 in this Guide.

RETIREE HEALTH PLAN PREMIUMS FY22

Travis County continues to pay a significant portion of the cost of your healthcare coverage. The amount Travis County subsidizes is determined annually and years of service and is subject to change. See rates below.

Retiree (Under 65) Monthly Premiums- United Healthcare Only- Rates Effective Oct 1, 2021

	Ret only	Ret+ 1 Adult	Ret + 1 Child	Ret+ Children	Ret+adult +Child	Ret+adult +Children
EPO	$493.00	$1,115.00	$648.00	$878.00	$1,427.00	$1,817.00
PPO	$295.00	$678.00	$369.00	$500.00	$910.00	$1,198.00
Consumer Choice	$167.00	$474.00	$213.00	$314.00	$678.00	$935.00
High Deductible	$141.00	$473.00	$199.00	$308.00	$687.00	$955.00

Retiree (Over 65) Monthly Premiums- United Healthcare Only Rates Effective Oct 1, 2021

	Ret only	Ret+ 1 Adult	Ret + 1 Child	Ret+ Children	Ret+adult +Child	Ret+adult +Children
EPO	$204.00	$357.00	$319.00	$500.00	$536.00	$715.00
PPO	$91.00	$188.00	$164.00	$294.00	$322.00	$454.00
Consumer Choice	$52.00	$134.00	$112.00	$228.00	$254.00	$371.00
High Deductible	$46.00	$131.00	$108.00	$229.00	$255.00	$379.00
Pharmacy Only Plan - Medicare Retiree Only			$43.00			
Pharmacy Only Plan - Medicare Retiree + Medicare Adult			$88.00			

Retiree (Over 65) Monthly Premiums - Humana Medicare Advantage - Rate Effective Jan 1, 2022

	Humana Medicare Advantage	EPO	PPO	Consumer Choice
Medicare Retiree Only	$47.28	The below rates are **TOTAL** costs with all Medicare Eligible Adults on Humana Medicare Advantage Plan and the rest on UHC.		
Medicare Retiree + Medicare Adult	$173.35			
Medicare Retiree + Adult without Medicare		$197.28	$141.28	$127.28
Medicare Retiree + 1 Child		$160.28	$118.28	$105.28
Medicare Retiree + 2 or more Children		$337.28	$245.28	$219.28
Medicare Retiree + Medicare Adult +1 Child		$286.35	$244.35	$231.35
Medicare Retiree + Medicare Adult + 2 or more Children		$463.35	$371.35	$345.35
Medicare Retiree + Adult without Medicare + 1 Child		$372.28	$273.28	$244.28
Medicare Retiree + Adult without Medicare + 2 or more Children		$547.28	$402.28	$358.28

TRAVIS COUNTY HEALTH INSURANCE

Travis County's medical coverage helps you maintain your wellbeing through preventive care and access to an extensive network of providers. Medical benefits are administered by United Healthcare. Choose the plan that best matches your needs and please keep in mind that the option you elect will be in place for the entire plan year, unless you have a qualifying event. Here are some items to consider when choosing a health plan:

- Premium costs- Premiums are the amount you pay per month for the health plan chosen
- Dependent coverage- Premiums are more expensive for dependent coverage
- How do you use the plan? Are you a high utilizer or low utilizer?
- Amount of copays
- Deductible amounts
- Out-of-pocket maximums
- Future expenses

Below is a brief description of each health plan offered.

Exclusive Provider Organization EPO Plan (In-Network Only)

This plan has the highest monthly premium for retirees and covers only in-network services. This plan has copays for most services including inpatient hospital, office visits and emergency room. Some services have both a copay and a deductible. The plan will cover 100% of charges once the deductible and copay has been made. There is a separate deductible and out-of-pocket maximum for pharmacy on this plan.

Preferred Provider Organization PPO Plan (In and Out-of-Network)

This plan offers both in-network and out-of-network coverage. It is important to understand that while you can access care from any doctor, if you use an in-network doctor your benefit will be much greater and your out-of-pocket will be much less. This plan consists of either copays or deductibles for services. There is a separate deductible and out-of-pocket maximum for pharmacy on this plan.

For Humana Medicare Advantage Plan info see page 10.

Consumer Choice Plan (In and Out-of-Network)

This plan has low monthly premiums. This plan is a "deductible first" plan where you have to pay the deductible before the plan will pay any coinsurance; this includes primary care and specialist office visits. Preventive care is covered at 100%. The deductible does not apply to prescription pharmacy benefits. The pharmacy on this plan is a percentage of the cost of the medication but includes minimums and maximums. This plan could be a good choice for retirees who rarely use the plan.

High Deductible Health Plan- HDHP (In and Out-of-Network)

This plan has the lowest monthly premiums of the four plans. This plan is a "deductible first" plan where you have to pay the deductible first before the plan will pay any coinsurance. Preventive care is covered at 100%. There is not a separate Pharmacy deductible on this plan. This plan includes a Health Savings Account that can be used to pay for eligible expenses. The HSA also has investment options. This plan could be a good choice for retirees who rarely use the plan.

Travis County Health Plan Comparison Chart

	EPO Plan (no new enrollments) *In-Network Only*	PPO Plan *In and Out-of-Network*	Consumer Choice *In and Out-of-Network*	High Deductible *In and Out-of-Network*
County Annual Contribution to Health Savings Account	$0	$0	$0	$0
Retiree Annual Contribution Limit for Health Savings Account	N/A	N/A	N/A	$3,550 Individual $7,100 Family
Deductible	$600 per Individual	$700 Individual $1,750 Family	$500 Individual $1,250 Family	$1,500 Individual $3,000 Family
Out-of-Network Deductible	Not Covered	$2,000 Individual $5,000 Family	$1,500 Individual $3,750 Family	$4,500 Individual $9,000 Family
Coinsurance	Plan pays 100% Member pays 0%	Plan pays 85% Member pays 15%	Plan pays 80% Member pays 20%	Plan pays 90% Member pays 10%
Out-of-Network Coinsurance	Not Covered	Plan pays 60% Member pays 40%	Plan pays 60% Member pays 40%	Plan pays 60% Member pays 40%
Medical Out of pocket maximum	$4,500 Individual $9,000 Family	$4,500 Individual $9,000 Family	$3,500 Individual $7,000 Family	$6,750 Individual $7,900 Family
Out-of-Network Medical Out of pocket maximum	Not covered	$6,000 Individual $12,000 Family	$6,000 Individual $12,000 Family	$13,300 Individual $26,600 Family
Pharmacy Out of pocket maximum	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family	Subject to Medical Out of pocket Maximum
1. **Acupuncture** (up to 30 visits)	$35 per visit - PCP $50 per visit - Specialist	$30 per visit - PCP $45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance
2. **Allergy Services in a Physician's Office** (no copay applies to injections or serum) **Allergy Testing**	$35 per visit - PCP 100%	$30 per visit - PCP 100%	Deductible & Coinsurance	Deductible & Coinsurance
3. **Ambulance Services - Emergency only** (Ground or Air Transportation)	$100 Copay	$100 Copay	Deductible & Coinsurance	Deductible & Coinsurance
4. **Chiropractic Services** (Limit of 3 treatments per visit and 25 visits per year)	$35 per visit - PCP	$30 per visit - PCP	Deductible & Coinsurance	Deductible & Coinsurance

	EPO Plan (no new enrollments)	PPO Plan	Consumer Choice	High Deductible
5. Dental Services - Accident related only Prior notification is required before follow-up treatment begins	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
6. Diabetic Supplies	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
7. Durable Medical Equipment Prior notification is required for retail cost over $1,000	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
8. Emergency Room	$300 per visit, waived if admitted to hospital	$300 per visit, waived if admitted to hospital	Deductible & Coinsurance	Deductible & Coinsurance
9. Employee Health Clinic (for ages 10 and over)	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	$50 Fee per visit
10. Eye Examinations Limited to one every calendar year	$35 per visit - PCP $50 per visit - Specialist	$30 per visit - PCP $45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance
11. Hearing Aid Benefit	$1,000 every 3 years	$1,000 every 3 years	$1,000 every 3 years	Deductible & Coinsurance
12. Home Health Care Services (provided in the home by an RN, LPN or contracted therapist) *Prior notification is required	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
13. Hospice Care Prior notification is required	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
14. Hospital - Inpatient Stay	$1,250 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
15. Maternity Services *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery	$1,250 copay per visit, then Deductible No Copay applies to Physician office visits for prenatal care after the first visit.	Deductible & Coinsurance No Copay applies to Physician office visits for prenatal care after the first visit.	Deductible & Coinsurance No Copay applies to Physician office visits for prenatal care after the first visit.	Deductible & Coinsurance

	EPO Plan (no new enrollments)	PPO Plan	Consumer Choice	High Deductible
16. **Mental Health Services - Inpatient, Outpatient and Intermediate** Must call Care Coordination for authorization prior to receiving Out-of-Network services	$1,250 copay, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
17. **Mental Health Services - Office Visit**	$35 per visit	$30 per visit	Deductible & Coinsurance	Deductible & Coinsurance
18. **Outpatient Surgery**	$600 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Diagnostic & Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine (requires notification)	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mammograms, Colonoscopies, and Endoscopies	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%
19. **Physician's Office Services**	$35 per visit - PCP & UHC Premium Designated Specialist $50 per visit - Specialist	$30 per visit - PCP & UHC Premium Designated Specialist $45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance
20. **Preventive Services**	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%	Plan pays 100% Member pays 0%
21. **Professional Fees for Surgical and Medical Services**	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
22. **Prosthetic Devices** Prior notification is required for retail cost over $1,000.	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Plan Pays 100% Member Pays 0%	Deductible & Coinsurance
23. **Reconstructive Procedures**	Same as 14, 17, 18 & 19	Same as 14, 17, 18 & 19	Same as 14, 17, 18 & 19	Deductible & Coinsurance
24. **Rehabilitation Services - Outpatient Therapy** (physical, speech, and occupational therapy)	$15 per visit for 15 visits in conjunction with an office visit; 16 or more visits $35 per visit - PCP $50 per visit - Specialist	$15 per visit for 15 visits in conjunction with an office visit; 16 or more visits $30 per visit - PCP $45 per visit - Specialist	Deductible & Coinsurance	Deductible & Coinsurance

	EPO Plan (no new enrollments)	PPO Plan	Consumer Choice	High Deductible
25. **Skilled Nursing Facility/Inpatient Rehabilitation Facility Services** (Limited to 60 days per year)	$1,250 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
26. **Substance Abuse Services** - Outpatient	$35 per visit	$30 per visit	Deductible & Coinsurance	Deductible & Coinsurance
27. **Substance Abuse Services** - Inpatient and Intermediate Network and Non-Network Benefits are limited to 2 series per lifetime. Must call Care Coordination for authorization prior to receiving Out-of-Network services.	Inpatient $1,250 copay per visit, then Deductible	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
28. **Transplantation Services** See summary plan description for possible limitations and more specific information	Inpatient $1,250 copay per visit, then Deductible Prior notification is required prior to any services	Deductible & Coinsurance Prior notification is required prior to any services	Deductible & Coinsurance Prior notification is required prior to any services	Deductible & Coinsurance Prior notification is required prior to any services
29. **Urgent Care Center Services**	$50 per visit	$45 per visit	Deductible & Coinsurance	Deductible & Coinsurance
30. **Virtual Visit**	$10 copay	$10 copay	Deductible & Coinsurance (estimated $49)	Deductible & Coinsurance (estimated $49)

The following procedures require notification of UHC Care Coordination PRIOR to Service.
Call 866.649.4873 if you need any of the following:

- Facility In-patient admissions: including acute hospitalizations, rehabilitation facilities, and skilled nursing facilities
- Home Health Services: All home based services, including Nursing, respiratory therapy, IV Infusion, and Hospice.
- End Stage Renal Disease Services
- Cosmetic Services (If covered by medical plan)
- Dental Services required due to an accident while covered under this plan
- Durable Medical Equipment (DME) with a retail cost of over $1,000 whether for purchase or rental
- Transplant Services: Request for Transplant Evaluation
- Inpatient Mental Health and Chemical Dependency (Notification also recommended for Outpatient Mental Health and Chemical Dependence)
- CT Scans, Pet Scans, MRI and some other diagnostic testing
- All elective surgeries will be reviewed for medical necessity

Medicare Advantage Plan- Humana

Humana Medicare Advantage plan replaces both original Medicare and the Travis County Health Plan, administered by United Healthcare, as your primary and secondary coverage. When you become eligible for Medicare and enroll in Medicare Parts A and B, contact Travis County Benefits Office with your Medicare information to begin enrollment in the Medicare Advantage Plan. A packet will also be mailed to your home address 90 days before you turn age 65.

Plan Highlights

- You must continue to pay for Medicare part B premiums; however you pay a lower monthly premium with Humana. You do not have to meet Medicare deductibles.
- There are no copays and deductibles for medical services (Acupuncture has a $25 copay).
- You can visit any provider that accepts Medicare and is willing to bill Humana.
- The Humana plan also offers additional benefits, such as no cost gym memberships along with health and wellness services.

Plan Medical Costs

	In-Network	Out-of-Network
Calendar Year Deductible	$0	$0
Doctor Visit Copay	$0	$0
Specialist Copay	$0	$0
Emergency Room Copay	$0	$0
Inpatient Care	$0	$0
Outpatient Surgery	$0	$0
Acupuncture Copay	$25	$25

Prescription Drug Benefit

	Retail Pharmacy	Mail Order Pharmacy
30 Day Supply		
Tier 1	$10	$10
Tier 2	$30	$30
Tier 3	$50	$50
Tier 4	$50	$50
90 Day Supply		
Tier 1	$20	$20
Tier 2	$60	$60
Tier 3	$100	$100
Tier 4	N/A	N/A

Humana Extra Benefits

HumanaFirst Nurse Advice Line

When a health issue comes up and you aren't sure what to do, Nurse Advice provides nurses who can help answer questions and offer support for your health concerns. This service is free for retirees and is available 24/7. This service is not for emergencies. Call 800.622.9529

SilverSneakers Fitness Program

Looking good and feeling fit are important at any age. This program provides retirees access to 16,000+ fitness center locations nationwide for free. This program includes access to exercise equipment, group classes and social events. Whether indoors or outdoors, beginner or experienced, we have classes fit for everyone. Visit www.SilverSneakers.com or call 888.423.4632 to enroll or for more information.

Go365

Now there's an easier way to stay in control of your health with Go365. This wellness and rewards program is only for Humana members and is available at no extra cost. It rewards you for completing your preventive screenings, getting your steps in and participating in other healthy activities that can help keep you on track. When you complete qualified activities, you earn rewards that can be redeemed for gift cards from certain retailers. Retailers include Amazon, Walmart, Shell, Target, and Kohl's. To learn more go to www.humana.com/Go365.

Well Dine Food Program

After an inpatient stay in a hospital or nursing facility, you may be eligible for 10 healthy, precooked frozen meals delivered to your door at no cost to you. Retirees may call 866.966.3257 to request participation in the program.

Virtual Visits

A virtual visit is a virtual doctor's appointment for nonemergency medical and behavioral/ mental health conditions such as bronchitis, sinus infection, depression and anxiety. Virtual visits should not replace your primary care provider, but can be used in nonemergency situations when your primary care provider's office is not available or convenient. No appointment is needed and you connect with doctor within minutes. There are 2 ways to talk to a doctor:

- Call 888.673.1992
- MDLIVE.com/yourbenefit
- Download the MDLIVE mobile app

MyHumana Mobile App

As soon as you receive your Humana member ID card, go to Humana.com and register for MyHumana. This is your personal, secure online account that allows you to access your specific plan details from your smartphone. You can review your plan benefits and claims, find providers in the networks and access digital ID cards.

Pharmacy Benefits

The prescription drug benefits are administered by OptumRx. Your dual medical/prescription card will be provided by UnitedHealthcare and will include OptumRx prescription information. Prescriptions for 30 days or less can be filled at any in-network retail pharmacy. Prescriptions for 90 days can be filled through the mail-order service or at any in-network retail pharmacy. OptumRx is the mail order and Specialty service provider.

Mail Order and Specialty Medications – OptumRx is the mail order and Specialty service provider.

Optum Specialty Pharmacy offers:

- Access to your medications at the plans lowest cost
- 24/7 access to pharmacists
- Clinical and adherence programs
- Medication supplies at no extra cost
- Refill Reminders

For more information, visit specialty.optumrx.com or call 855.427.4682

How will I order my prescriptions from OptumRx home delivery?
Once your coverage begins, there are four ways to place a home delivery order:

- By e-prescribe. Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe*.
- Go online. Visit the website on your member ID card.
- By mobile app. Open the OptumRx app, which you can download from the Apple® App Store® or Google Play™.
- By phone. Call the toll-free number on your member ID card.

	EPO and PPO Health Plan		Consumer Choice Health Plan	High Deductible Health Plan
	30 Day Supply	90 Day Supply		
Annual Pharmacy Out of Pocket Maximums	$2,500 Individual $5,000 Family		$2,500 Individual $5,000 Family	None- Applies to Medical OOPM
Tier 1- Generic	$10	$20	20% Coinsurance ($5 min, $35 max)	Deductible & Coinsurance
Annual Deductible (Tier 2 & 3 Only)	$50 Individual $125 Family	$50 Individual $125 Family	None	None
Tier 2- Preferred	$35	$70	20% Coinsurance ($20 min, $60 max)	Deductible & Coinsurance
Tier 3- Non-Preferred	$55	$110	20% Coinsurance ($40 min, $100 max)	Deductible & Coinsurance

Prior Authorization – For certain medications, prior authorization will be needed from your doctor. You and your doctor will be alerted by your pharmacy when a prior authorization is needed. Prior authorization guidelines are determined on a drug-by-drug basis and may be based on FDA and manufacturer guidelines, medical literature, safety, appropriate use and benefit design.

Quantity Limits - There may be a limit on the number of units per day, per period or per prescription based on FDA-approved indications and normal monthly usage.

Pay the Difference - Participants will pay the brand copay and the difference in cost between the brand drug and the corresponding generic drug when a true generic is available and deemed acceptable by the prescribing physician.

Additional Tools and Resources - OptumRx app features include:

- Digital ID Card that can be used by pharmacists and doctors

- Access to prescription claims information (mail and retail), including days until next refill
- Member profile, including cost information for prescriptions and the ability to identify cost savings
- Pharmacy help desk phone numbers
- A secure connection to personal health information, only accessible with user name and password

United Healthcare Tools and Resources

NurseLine

In non-emergency situations, free help is only a phone call or click away. NurseLine is available 24/7 and allows you to speak with an experienced registered nurse who can give you treatment advice and determine if it's necessary for you to see a doctor. The nurse can also help locate a doctor or urgent care facility that is near your home or office. This service is free and may save you a trip to the doctor! Call the number on the back of your ID card.

Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer immediately with or without an appointment. Most visits take less than 10 minutes and doctors can write a prescription, if needed, that you can pick up at the pharmacy of your choice. During your visit you will be able to talk to a doctor about your symptoms and treatment options. You must have a smart phone, tablet or computer with a camera so that the doctor can see and speak to you.

Conditions commonly treated:

- Bladder infection/urinary tract infection
- Cold/flu
- Allergies
- Diarrhea
- Fever
- Pink eye
- Rash
- Sinus problems

Virtual visits are not good for anything that may require a hands on exam or emergencies. Download Doctor on Demand App on your smartphone or tablet to access virtual visits. You may also login to myuhc.com to access virtual visits.

MyUHC.com

The www.myuhc.com web site offers online tools, resources and information that are both practical and personalized. Here are just some of the things you can do:

- View benefits and eligibility
- Estimate treatment costs
- View claim documents
- Find a network doctor
- Enroll in online health and wellness programs

To get the most out of your benefits:

1. Go to www.myuhc.com and select Register Now.
2. Enter the required information.
3. Accept the delivery message and start receiving your communications online.

Health4Me Mobile App

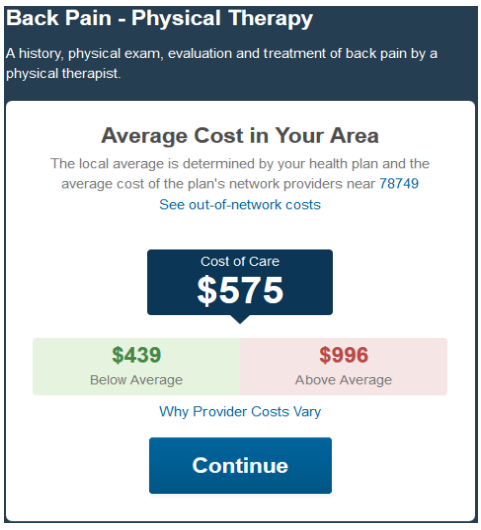
United HealthCare's Health4Me provides instant access to you and your family's critical health information – anytime and anywhere. Whether you want to find physicians near you, check the status of a claim or speak directly with a nurse, Health4Me is your go-to resource for anything related to your health. Download the Health4Me app from the Apple iTunes App Store and the Google Play store.

myHealthcare Cost Estimator

Using your benefit information, myHealthcare Cost Estimator shows you the estimated cost for a treatment or procedure, and how that cost is impacted by your deductible, coinsurance and out of pocket maximum. Getting an estimate of what you will be responsible for paying out of your pocket will provide you with useful information for planning and budgeting.

The more you use myHealthcare Cost Estimator, the more you will see that not all doctors are the same. Depending on what you are looking for, you could see a wide range of estimates for the same procedure or treatment. You can then use this information to help decide where to get care or to discuss with your doctor.

Just search for the condition (e.g., back pain) or treatment (e.g., physical therapy) you would like an estimate for, and the Cost Estimator will show you doctors and locations that offer those services in your area. You will also be able to learn about your care options, compare estimated costs, see quality and cost efficiency ratings, and even map out where you'll be going. Most importantly, you will be able to make an informed decision about what's best for you.



Real Appeal

Real Appeal takes an evidence-based approach to support weight loss. This program helps people make small changes necessary for long-term health results.

Key Program Components:

- Interactive coaching, live over the internet
- Weekly group coaching
- Ongoing one-on-one personalized coaching
- Program success guide, nutrition and fitness guide
- Blender, body weight scale, food scale, workout DVD's, fitness band, pedometer and more
- Web-based participation through web platform or mobile app
- Online or mobile tools to track nutrition and physical activity

To enroll visit www.tccare.realappeal.com

Cancer Support Program

Specialized cancer nurses offer needed support to participants throughout cancer treatment, recovery and at the end of life to assist with treatment decisions and improve health care experience. Experienced, caring nurses from the program are available to support participants in several ways. Here are a few:

- Disease and treatment decision/education
- Manage symptoms and side effects
- Second opinion support
- Access to Centers of Excellence (COE)
- Clinical coverage review of treatment, prescriptions and clinical trials
- Drug management support
- Administration of benefits (i.e. Travel and Lodging)
- Survivorship support
- End of life/hospice decision making

Spine and Joint Solutions

This program helps people who are considering:

- Spinal fusion surgery
- Spine disc surgery
- Total hip or knee replacement

Once you enroll in the program, you will be working directly with a nurse who will help get answers so you can make confident decisions. The Spine and Joint Solution gives you access to some of the nation's leading orthopedic facilities through UHC's Centers of Excellence (COE) network.

Personal Health Support/Case Management

Personal Health Support is a unique program for individuals who are living with a chronic condition or complex health care needs. The program provides a high level of support, educational tools, and telephone access to a registered nurse who is assigned to employees and their families. They tell employees more about the benefits available to them, offer information about a wide range of health issues and direct them to UnitedHealth Premium® and Centers of Excellence network physicians and facilities. The nurse may also discuss and refer to the disease management services. These resources can help individuals better manage chronic conditions such as diabetes and asthma, or other serious illnesses, including cancer.

Personal Health Support includes, but is not limited to:

- IV therapy, antibiotics, and chemotherapy
- Hyper-alimentation
- AIDS
- Premature births
- Birth defects
- Chronic muscle disease, such as Multiple Sclerosis
- Head injury and spinal cord injury
- Strokes and cardiac conditions
- Ventilator dependency
- Respiratory support
- Cystic Fibrosis
- Burn conditions
- Diabetes
- Asthma
- Heart Disease
- Recent Hospital stay

Rally Health Survey

With the online Rally Health Survey, personalized Missions, rewards and connections to wearables like Fitbit®, we make it easier for you to get motivated to be healthier. When you sign up for Rally, the first thing you'll learn is your Rally Health Age, which tells you how your body is feeling right now. Then you can start exploring all the great digital tools that may help you make healthier choices based on your life, schedule and needs.

To get started, visit www.myuhc.com and once you are logged in click on "Rally Health Survey" link or click on the Rally icon.

Diabetes Health Plan

The Diabetes Health Plan is a condition-based program with enhanced benefits that may potentially help prevent diabetes and slow its progression. Diabetes Health Plan encourages members to follow evidence-based medicine guidelines and their doctor's care plan while removing financial barriers to care. Employees have $0 copays or 100% coverage after meeting their deductible for HSA plans for visits related to diabetes, prediabetes and/or high blood pressure and high cholesterol as well as 100% coverage for tier 1 and tier 2 diabetes-related medications and supplies.

Travis County Health Clinic

Travis County has three on-site health clinics staffed by physicians and medical care professionals available to Retirees and Dependents who are at least 10 years old and are covered on one of the Travis County Health Plans or the Humana Medicare Advantage Plan.

The mission of the Travis County Health Clinic is to reduce health care costs by partnering with health plan participants and empowering them, through education, prevention, medicine and personal responsibility, to make choices that lead to a healthier lifestyle which reduce the cost of chronic illness and promotes workplace productivity.

Three clinic locations are available to plan participants for physicals, screening, disease management, immunization and fast track appointments. Limited fast track appointments for minor illnesses or injuries are available for the same day or next day visits.

Services Offered include:

- Diabetes management
- Cholesterol/Lipid management
- High blood pressure management
- Asthma
- Allergy management (not allergy injections)
- Weight management
- Depression treatment
- Tobacco cessation
- Alcohol cessation
- Annual Physicals
- Pregnancy Testing

Clinic Hours of Operation

Downtown Clinic
700 Lavaca, 9thFloor, Suite 980
Phone: 512-854-5509
Mon -Thurs 7:30am – 5:30pm
Friday 7:30 am– 11:30am
(Closed for lunch 12- 1pm)

Airport Blvd. Clinic
5501 Airport Blvd, Suite 201
Phone: 512-854-7998
Mon - Tues 7:30am – 5:30pm
(Closed for lunch 12- 1pm)

Del Valle Clinic
3518 FM 973 South
Phone: 512-854-1282
Wed- Thurs 7:30am – 5:30pm
Friday 7:30 am– 11:30am
(Closed for lunch 12- 1pm)

Referrals: Chronic pain management will be referred to specialist within the UHC network.

Prescription refills: Requires initial doctor's visit (per protocol). Generic drugs will be prescribed when available.

For urgent care issues or medical questions before and after clinic hours, you may call the 24 hour United Healthcare Nurse Line on the back of your United Healthcare ID card.

DENTAL INSURANCE

Travis County offers four dental plans administered by UnitedHealthcare. The following information describes the details of each dental plan including the monthly premium information. There is a Dental HMO (DHMO) plan, two Preferred Provider Organization (PPO) plans and a Preventive Only plan.

You can find a dental provider in the UnitedHealthcare network by visiting www.myuhc.com, Or you may call customer service at 877.816.3596.

Prepaid DHMO Plan

The Prepaid DHMO Plan offers benefits through a network of Plan Dentists. When you enroll for benefits, treatments you receive from your selected Plan Dentist will be provided at reduced fees called copays. This plan does not provide coverage for out-of-network providers.

Plan features include: No deductible, no copays for most preventive services, coverage for pre-existing conditions, and no annual maximum for services.

Basic PPO Plan

Plan features include: Freedom to choose any dentist, including specialists, PPO options available, limited rollover reward amount for unused annual maximum amounts.

How the Plan Works

This dental plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. Benefits are paid after any applicable deductible has been met, up to the annual maximum.

Network and Non-Network Discounts

The Basic PPO plan allows employees to have access to the National Options PPO 20 providers and take advantage of their fee discounts. Dentists participating in the National Options PPO networks have agreed to discount their usual fees. Treatment is available from dentists who do not participate in the network, but their fees are subject to a Maximum Allowable Charge (MAC). Patients are responsible for fees in excess of the MAC.

Preferred PPO Plan

Plan Features Include: Freedom to choose any dentist, including specialists, PPO options available, and limited rollover reward amount for unused annual maximum amounts.

How the Plan Works

This dental plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. Benefits are paid after any applicable deductible has been met, up to the annual maximum.

Network and Non-Network Discounts

This dental program offers a PPO (Preferred Provider Organization) through National Options PPO 30 that provides a variety of cost saving features. Although you may visit any dentist you choose, you will receive maximum savings if you visit a National Options PPO provider. Dentists participating in the network have agreed to discount their usual fees. The allowable amount for non-participating dentists is based on the usual and customary. Patients are responsible for fees in excess of usual and customary. This plan provides a better benefit when seeing a non-network provider than the Freedom Basic PPO.

Preventive Only Plan

Plan Features Include: Freedom to choose any dentist, lower premium cost, preventive only coverage.

How the Plan Works

This dental plan provides coverage for preventive services only. There is no deductible and a $750 annual maximum.

Network and Non-Network Discounts

This dental program offers a PPO (Preferred Provider Organization) through National Options PPO 30 that provides a variety of cost saving features. Although you may visit any dentist you choose, you will receive maximum savings if you visit a National Options PPO provider. Dentists participating in the network have agreed to discount their usual fees. The allowable amount for non-participating dentists is based on the usual and customary. Patients are responsible for fees in excess of usual and customary.

Dental Plan Premiums

Monthly Premiums

	Prepaid DHMO Plan	Basic PPO Plan	Preferred PPO Plan	Preventive Only Plan
Retiree Only	$11.14	$22.51	$35.20	$12.53
Retiree + 1 Adult	$17.91	$42.82	$70.36	$25.06
Retiree + 1 Child	$17.91	$42.82	$70.36	$25.06
Retiree + 2 or more Children	$24.03	$70.52	$110.10	$34.68
Retiree +1 Adult + 1 Child	$24.03	$70.52	$110.10	$34.68
Retiree + 1 Adult + 2 or more Children	$28.10	$93.65	$145.30	$50.16

Dental Plan Comparison

	DHMO Plan	Basic PPO	Preferred PPO	Preventive Only Plan
Calendar Year Deductible	$0	$50	$50	$0
Annual Maximum	No max	$1,500	$2,000	$750
Preventive services: Routine oral exams, routine cleanings, fluoride treatment (frequency limitations)	100% (no copays)	100% (no deductible)	100% (no deductible)	100% (no deductible)
Restorative services: Fillings, all other x-rays, simple extractions	Various copays	Plan Pays 80% Member Pays 20%	Plan Pays 80% Member Pays 20%	Not covered
Major services: Crowns, bridgework, dentures, oral surgery, extractions, endodontics (root canals), periodontics (treatment of gums), implants	Various copays *implants not covered	Plan Pays 50% Member Pays 50%	Plan Pays 50% Member Pays 50%	Not covered
Orthodontia	Various copays	Plan Pays 50% up to a $1,000 lifetime max	Plan Pays 50% up to a $1,000 lifetime max	Not covered
Out-of-Network Coverage	None	Contracted Rates	90th Percentile of UCR	90th Percentile of UCR

VISION INSURANCE

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, Travis County offers a comprehensive vision benefit provided by Davis Vision. Through Davis Vision's provider network, you will receive a vision examination, as well as eyeglasses (lenses and frames), or contact lenses in lieu of eyeglasses.

Easy Benefit Access

With Davis Vision, you are able to visit any provider you choose, but you maximize your savings when you visit a network provider. You can locate a provider by logging on the www.davisvision.com and select "Find a Provider" or by calling 877.923.2847

	In-Network Benefits	Out-of-Network Benefits If you choose an out-of-network provider, you will be reimbursed up to:
Eye Examination	$10 copay	$45
Pair of Lenses (once every plan year)	Standard single-vision, lined bifocal, or trifocal lenses after $25 copay	Single vision $40 Bifocal $60 Trifocal $80 Lenticular $100
Additional Lens Options and Coverage (once every plan year)	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings	
Frames (once every other plan year)	Up to $130 retail allowance toward provider-supplied frame plus 20% off cost exceeding the allowance *OR* Any Fashion or Designer frame from Davis Vision's exclusive Collection (with retail values up to $175), Covered in Full *OR* Any Premier frame from Davis Vision's exclusive Collection (with retail values up to $225), Covered in Full after an additional $25 copay	$50
Contact Lenses in Lieu of Eyeglasses (once every plan year)	Up to $150 allowance toward provider-supplied contacts plus 15% off cost exceeding the allowance. Standard and Specialty Contacts – Evaluation, fitting fees, and follow-up care, $25 copay applies *OR* Davis Vision Collection contact lenses, evaluation, fitting fees, and follow-up care, Covered in Full after $25 copay(Up to 4 boxes of disposable lenses). *OR* Medically necessary with prior approval, Covered in Full	Elective $150* Necessary** $225

Additional Lenses Coverages and Copays

Davis Vision Collection Frames: Fashion | Designer | Premier ..... $0 | $0 | $25
Tinting of Plastic Lenses $0
Oversize Lenses $0
Scratch-Resistant Coating $0
Ultraviolet Coating $12
Anti-Reflective Coating: Standard | Premium | Ultra ..... 35 | $48 | $60
Polycarbonate Lenses ..... $0/4-$30
High-Index Lenses $55
Progressive Lenses: Standard | Premium | Ultra ..... $50 | $90 | $140
Polarized Lenses $75
Plastic Photosensitive Lenses $65
Scratch Protection Plan: Single Vision | Multifocal Lenses ..... $20 | $40

Out-of-Network Providers
If you visit an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.

Important Tip
Your $150 contact lens allowance is applied to the contact lens fitting and evaluation fee and the purchase of contact lenses. For example, if the contact lens fitting and/evaluation fee is $30, you will have $120 towards the purchase of contact lenses.

Value-Added Features
- Replacement contacts through www.DavisVisionContacts.com for mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Vision Plan Premiums

Coverage Level	Monthly Premium
Retiree Only	$4.26
Retiree + 1 Adult	$8.10
Retiree + 1 Child	$8.10
Retiree + 2 or more Children	$8.96
Retiree +1 Adult + 1 Child	$9.60
Retiree + 1 Adult + 2 or more Children	$12.38

LIFE INSURANCE

Retirees are eligible to enroll in life insurance for themselves and covered spouses. If you enroll upon retirement, the Basic Life benefits are Guarantee Issue and no underwriting approval is required. To purchase coverage listed under "Optional Amount" in the table below you must complete an Evidence of Insurability (EOI) form and it must be approved by Cigna. Listed below are the coverage options and rates for retirees under age 70 as well as retirees who are age 71 or higher.

Retirees age 70 or less	Basic Amount	Monthly Cost	Optional Amount	Monthly Cost	Total Available	Total Monthly Cost
Retiree Life	$15,000	$2.08	$10,000*	$4.84	$25,000	$6.92
Retiree Spouse Life	$7,500	$2.08	$5,000*	$4.84	$12,500	$6.92

Retirees age 71 or higher	Basic Amount	Monthly Cost	Optional Amount	Monthly Cost	Total Available	Total Monthly Cost
Retiree Life	$5,000	$5.90	$5,000*	$8.80	$10,000	$14.70
			$10,000*	$17.60	$15,000	$23.50
			$15,000*	$26.40	$20,000	$32.30
Retiree Spouse Life	$2,500	$2.95	$2,500*	$4.40	$5,000	$7.35
			$5,000*	$8.80	$7,500	$11.75

**Optional Life requires underwriting and approval from carrier. Complete the Evidence of Insurability (EOI) form, which is available online and send to address on form (unless you have already been approved in a prior year).*

HEALTH SAVINGS ACCOUNT (HSA)

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependents. You own and administer your HSA. Contributions to an HSA are tax free and withdrawals for qualified expenses are also tax free. The money in this account rolls over from year to year if you do not spend it. This account is also portable, which means it stays with you if you switch medical plans or drop medical insurance through the County.

Once enrolled in this account, Optum Bank will issue a debit card, giving you direct access to your account. When you have a qualified expense, you can use your debit card to pay. If you use your credit card or other form of payment to pay for your eligible expenses, you can reimburse yourself from your HSA. Eligible expenses include doctors' office visits, eye exams, prescriptions, laser eye surgery and more. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov. There are no receipts to submit for reimbursement, however you would need to keep your receipts in case the IRS audits you. Retirees are able to upload and save their receipts on the Optum App or website.

To be eligible for the HSA, you must meet the requirements below which are determined by the IRS.

- You must be enrolled in the High Deductible Health Plan
- You and your enrolled dependents cannot be claimed on another person's tax return
- You cannot be enrolled in any other health plan
- You cannot be enrolled in Medicare or Tricare
- You and your enrolled dependents cannot be enrolled in a Healthcare FSA
- You must provide a physical address to Optum Health Bank (no P.O boxes)
- You must be a legal resident of the United States

HSA Contribution Limits

Contributions to an HSA are tax-free and can be made directly through Optum on a pre-tax basis. The money in this account (including interest and investment earnings) grows tax-free as well. As long as the funds are used to pay for qualified expenses, they are also spent tax-free. Per IRS regulations, if funds are used for purposes other than qualified expenses and you are younger than age 65, you will pay federal income tax on the amount withdrawn plus a 20% penalty tax. At age 65, you are no longer eligible to contribute to a HSA. After age 65, the money in your HSA does not have to be used for eligible expenses. An HSA is a great way to save for post-retirement healthcare needs.

Each year, the IRS places a limit on the maximum amount that can be contributed to the HSA. For 2021, contributions are limited to the following:

Retiree Only	$3,650
Retiree + Dependent	$7,300
Catch-Up Contribution (Age 55+)	$1,000

REQUIRED NOTICES

Your Prescription Drug Coverage and Medicare
Beneficiary Creditable Coverage Disclosure Notice

This notice has information about your current prescription drug coverage with Travis County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in this area. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. On January 1, 2006, new prescription drug coverage became available to individuals with Medicare Part A. This coverage is available through Medicare prescription drug plans, also referred to as Medicare Part D. All such plans provide a standard, minimum level of coverage established by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Travis County has determined that prescription drug coverage offered through the County health plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Other Important Considerations

- If you currently have prescription drug coverage through the County medical plan, you may choose to enroll in Medicare Part D annually between October 15 and December 7, or when you first become eligible for Medicare Part D.
- If you decide to join a Medicare drug plan, your current Travis County medical coverage will not be affected.
- If you do decide to join a Medicare drug plan and drop your current Travis County coverage for your dependents, you will not be able to get this coverage back during an Open Enrollment period.
- You should also know that if you drop or lose your current coverage with Travis County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium.
- You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.
- If you are enrolled in Medicare Part D or a Medicare Advantage Plan and are also enrolled in the County medical plan, you may have duplicate prescription coverage. If you would like to review your coverage or for more information, contact the Benefits Team at 512-854-0404.

More information about Medicare Part D prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. You can also:

- Visit medicare.gov for personalized help.
- Call the Health and Human Services Commission of Texas at 888-834-7406 or 800-252-9330.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

Financial assistance may be available for individuals with limited income and resources through the Social Security Administration (SSA). For more information, visit the SSA website at socialsecurity.gov or call 800-772-1213. TTY users should call 800-325-0778.

Newborns Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours).

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for a mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymph edemas.

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and copays consistent with other coverage provided by the plan.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Visit www.healthcare.gov for more information about the Marketplace. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are the spouse of a retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-retiree dies;
- The parent-retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child"

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- Death of the retiree;
- The retiree becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:
Travis County Human Resources Management Department
c/o Benefits Division
PO Box 1748
Austin, TX 78767

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the retiree dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

If you have any questions about your rights to COBRA continuation coverage, you should contact:

United Healthcare
P.O. Box 221709
Louisville, KY 40252

Customer Care Center
Toll Free: 877.237.8576
email: cobra_kyoperations@uhc.com

Health Insurance Portability and Accountability Act (HIPAA) Notice

Monisha Perryman
HIPAA Compliance and Privacy Officer
Phone: (512) 854-6278 or ext. 46278
Email: privacy@traviscountytx.gov

Travis County Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Travis County maintains electronic health records and will not use or disclose your health information except as described in this notice. Please review it carefully.

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Bill for your services
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
  File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your health plan to coordinate payment for your health care.

Administer your plan

We may disclose your health information to our health plan administrator.

Example: We contract with a third party to administer the health plan, and they need information to enroll you and to pay claims.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your health and claims records

- You can ask to see or get an electronic or paper copy of your health and claims records and other health information we have about you when you submit a written request. Ask us how to do this.
- We will provide a copy or a summary of your health information, within 15 days of your request if we maintain it in an electronic format. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Privacy Officer at the email address and telephone number provided on the top of page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Changes to the Terms of this Notice.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.